Selected

Medico-Religious Articles

from

The Hampden Hippocrat

Hampden District Medical Society

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To the Clergy of Hampden County:

The enclosed is a reprint of a series of articles written by members of the Medical-Religious Committee of the Hampden District Medical Society. In as much as the subject matter is of general interest, clerical members of the committee suggested that we send a reprint of it to the Clergy of the Hampden County.

On Tuesday April 7, 1964, at eight o'clock in the evening there will be presented by the Medical-Religious Committee at the Municipal Hospital Auditorium, 1400 State Street, Springfield, a Panel Discussion of subjects of mutual interest. There will be three clergymen and three physicians, representing some of the major denominations. We hope that you will enjoy reading this reprint and that you will be able to come to the April meeting.

Respectfully yours,

John J Bandeian

Medical-Religious Committee,
John J. Bandeian, M.D. Chairman,
Hampden District Medical Society

JJB/nr

OUR MEDICO-RELIGIOUS COMMITTEE

By John J. Bandeian, M.D., Chairman
Medico-Religious Committee, H.D.M.S.

In their daily ministrations to the sick the physician and the clergyman have one interest in common — the patient. In order to effect a cure in a bodily ailment the physician often is called upon to delve into the spiritual and religious needs of his patient. Without meeting these needs, complete cure is seldom if ever possible. The clergyman, likewise, prays that his parishioners always maintain the best of health. Rev. Paul B. McCleave, Director of the Department of Medicine and Religion of the American Medical Association, states that where sickness and suffering are concentrated, spiritual needs are felt more acutely. Recognizing this need of both the physician and the clergyman in treating man, the American Medical Association established in September 1961 the Department of Medicine and Religion "to advance - - - the improvement of total care of the patient. The purpose of this new department is to bring together physicians and clergymen of all faiths for the study and discussion of their problems and common concern of the total welfare of the patient - - - . The purpose of this program is to help everyone recognize that man in his total being requires the aid and assistance of all who are available for total health."

From the dawn of civilization until the Age of Enlightenment, medicine and religion were administered by the priests. During and following the Renaissance there was a separation of the two professions. In recent times, and especially in the past 50 years, medical science has made tremendous advances but we still have to delve into methaphysical spheres to explain some clinical manifestations. This has been especially true in the field of psychiatry. Dr. John M. Billinsky, Professor of Pastoral Psychology and Clinical Training at Andover Newton Theological School, states that it was the medical profession, headed by the late Richard C. Cabot and Walter B. Cannon of Harvard Medical School, which called for a closer cooperation between medicine and religion, pointing out that it was not enough to heal man's wounds, for man himself, the whole man, must also be healed. Dr. Billinsky quotes Dr. Cannon that " . . . as far as the patient was concerned, every illness was spiritual in its nature, and that, apart from the patient, illness had no meaning at all." These authors conclude that since the state of health in a patient is affected by his physical, mental, spiritual, and social make-up, illness in any one of those areas may affect any or all of the remaining areas.

In 1961 the A.M.A. established the Department of Medicine and Religion. In charting the course of this department the A.M.A. sought advice and guidance from many sources, and especially from the leaders of the various faiths. When our District Society organized about two years ago the Medico-Religious Committee, it followed a similar pattern. As a result, our committee includes not only physicians but also clergymen representing the three major denominations in this area. In our monthly "workshop" meetings, specific problems are presented and discussed by the several members. Each one outlines the particular Medico-Religious philosophy of his own religion. Much has been accomplished. It is hoped that by next January or February we will be ready to present a Medico-Religious panel, including guest clergymen, before our entire Society membership.

In the meantime, we are grateful to our spiritual committee members for their willingness to outline the philosophy, customs, and traditions of their respective religions. It is hoped that their articles, which appear elsewhere in this issue, will be read and studied carefully by every member of our Society.

THE LAST SACRAMENTS ADMINISTERED TO A DYING CATHOLIC

By Rev. Joseph A. Russell, Director of Hospitals
Diocese of Springfield
(Member, Medico-Religious Committee)

From Sacred Scripture we know that Almighty God, when creating our first parents, endowed them with an immortal soul together with supernatural and preternatural gifts. Through the sin of our first parents these gifts were lost to mankind, but through divine mercy mankind was given another chance and God promised man that He would send into this world a Redeemer Who would satisfy Divine Justice. His Divine Son, Jesus Christ, accomplished this through His death on Calvary and during His life here on earth instituted the seven Sacraments as channels of receiving sanctifying grace, whereby through the worthy reception of these Sacraments we are restored to a supernatural life.

Ordinarly, we use the expression "Last Sacraments" in reference to the Sacrament of Penance or Confession of one's sins to the priest by a dying person, Holy Communion received as Viaticum, and the Sacrament of Extreme Unction. More recently, the latter Sacrament is called "the Sacrament of the anointing of the sick."

The individual attending a sick person realizes that the patient is often weakened in his mental powers, as well as in his physical strength. There is the constant battle to maintain a Christian resignation to suffering. Certainly, the sick person has a difficult spiritual battle to fight and, in his weakened condition, the need for spiritual aid is indeed great.

The soul approaching death is nearing the most solemn moment of its existence. It needs all possible spiritual aid to combat the final temptations of this life and to maintain itself in the state of sanctifying grace. No conscientious person would ever allow a patient, through his or her negligence, to die without all the spiritual help that could be given to him.

When a doctor, in caring for his patient, recognizes that the patient is critically ill or in danger of death, he has the obligation to notify a responsible member of the family of the seriousness of the patient's illness. If this patient is a Catholic, the doctor has the further obligation to inform the responsible member of the family that a priest should be called in to administer the last sacraments.

To their everlasting credit, the members of the medical profession are to be highly commended for the admirable manner in which they have carried out this obligation. Actually, the baptized Catholic in danger of death is solemnly bound by both Divine and ecclesiastical law to receive Holy Communion. Needless to say, should the patient be delirious or nauseated, it would not be fitting to administer Holy Eucharist.

In order to receive the Sacrament of Extreme Unction, three conditions must be verified: a) the patient must be a baptized Catholic, b) the patient must have had the use of reason, and c) the patient must be in danger of death from sickness or an accident. How grave must the danger be in order to justify the administration of Extreme Unction? All that is required is that there be a probable danger of death. The probability must, of course, rest on solid grounds, but a man may be in probable danger of death even though the

likelihood of his recovery is more probable even if death is not expected in a matter of hours. Whenever a patient's condition is so serious that there is a reasonable expectation that it may produce death, he is capable of receiving Extreme Unction.

Frequently, the priest and the doctor in their respective spiritual and professional administrations attend a patient who is a victim of a terminal illness. The question often arises is this: Should the patient be made aware of the seriousness of his illness and when should this be done? To reach a satisfactory answer to this question, and at the same time exercise prudence in this particular case, the priest and the doctor attending the patient can and should be mutually cooperative and helpful. It is imperative that the Last Sacraments be administered, if possible, while the patient is conscious. The very prevalent attitude among many that the priest should not be called to administer the Sacrament of Extreme Unction until death is imminent should be eradicated. When this happens, a grave injustice is done to the spiritual welfare of the patient. The patient is deprived in this case of the many spiritual benefits and aids ordinarily gained through the administration of the Sacraments when consciously received.

The well informed Catholic realizes that there is no lasting city here on earth; that God has created him to live on earth for a time only and that He has planted in man's soul to desire to live forever with God in Heaven — the only place where he will find perfect happiness. Hence, a Catholic welcomes the priest on such an occasion. For he realizes that the priest comes to him as God's representative to administer the Sacraments — the channels of sanctifying grace by which he is spiritually fortified on his journey to his eternal home.

Oftentimes, the priest and the doctor in the conscientious fulfillment of their calling receive little human consolation. However, we who have been blessed with the gift of Faith find great comfort in the realization that in the conscientious fulfillment of our duties to the dying, we are co-workers, priests and doctors, and instruments of God in helping precious human souls attain their eternal goal. Nothing could be more rewarding!

SOME NOTES ON THE DOCTOR AND RELIGION

By Rabbi Samuel H. Dresner
Beth El Temple, Springfield
(Member, Medico-Religious Committee)

The doctor, Jew or Christian, needs a much more definite awareness of his own distinctive vocation than he has frequently shown in the past. It is clear that this involves much more than that he should be efficient, conscientious and unselfish, as those virtues are understood according to the standards current in the profession in his own time, which is certainly not to suggest that these are virtues which are lightly to be esteemed.

It involves more than that he should possess, in addition to those virtues, a well-defined attitude to the important medical moral issues. It involves the acceptance of at least three relatively new responsibilities on his part. The *first* is that he should strive to see his whole task as a doctor in the light of his faith and to discover how his attitude to his task is controlled by those re-

ligious insights into the nature of life and death and suffering. *Secondly,* he must defend his profession against the attitude which regards medicine simply as a technique which need not concern itself unduly with its moral implications. *Thirdly,* he must recognize that the social framework in which he operates as a doctor cannot be taken for granted but must constantly be submitted to critical examination if he is not to slip unconsciously into profitless activity or to miss an opportunity of doing useful work.

The average busy doctor may feel on reading this that this is making impossible demands on his already overcrowded life. No one will pretend that it is easy and the doctor may legitimately complain that very little guidance is available in the church or synagogue to help him in trying to do it. At the same time, it is not impossible, for what it demands is not so much more time and energy or any spectacular new activities, but a different way of looking at familiar tasks. But it will be immeasurably easier for the faithful doctor if he possesses the fellowship, advice and cooperation of others engaged upon the same enterprise. Indeed, without such help he may very well find that he is unable to sustain it.

THE PROBLEM OF IMPATIENCE

By Reverend Clayton J. Steele
South Congregational Church
(Member, Medico-Religious Committee)

It is an old adage, "Patience is a virtue, seldom in a woman and never in a man!" In sickness and in health impatience ranks high as a disturber of human equilibrium. One of the greatest problems physicians and clergymen have to deal with is impatience. Impatience quite often grows out of the peculiar nature of man to be overconfident of his own resources and, as a hospital patient, it comes at a time he is least able to prove it! It becomes a double problem and an awkward situation when the patient projects his feelings of impatience as guilt, rebellion or a complete rejection of the best that can be done for him. How often we have heard the patient complain, "I'm not making progress at all," or, "The doctor doesn't tell me anything." No doubt the physician has heard the non-medical question, "What have I done to deserve this?"

Two things seem to be most urgent and particularly important when the patient's uneasiness about his own recovery takes the form of emotional involvement leading to a concern that is all out of proportion to the normal recovery pattern. First, it seems logical to assume that the attending physician can alleviate a great deal of emotional distress of the patient by informing him of the nature of the illness, duration and any irregularities the patient might expect in his own case. The silent treatment may save a lot of time but may, according to the degree of emotional stress, extend the illness. Healing is an attitude as well as medicine and surgery. Patients are persons as well as a disease with a record of diagnosis and treatment. Healing is as much what a patient thinks about himself and how he feels as what others think about him and do for him. A patient needs a chance to do more than worry and wait.

Secondly, the clergyman has an important role to play in the problem of impatience if he possesses those spiritual qualities that will lead the patient to experience his confidence. Somewhere in the clergy-patient encounter the Scriptural wisdom has a practical application, namely, "that the trying of your faith worketh patience." The clergyman, most of all, needs to help the patient find a working base for faith and motivation for courage. Faith eliminates doubt and establishes a new sense of trust in others and what they are endeavoring to do for him. Courage turns negative feelings into the active and positive ingredients of mental health. It is precisely at this point that the clergyman can supply the spiritual climate to induce a healthy attitude toward God's own time in the healing processes.

Finally, it appears that the basis for physician-clergyman understanding and cooperation is the welfare of the patient. To the patient in the emotional distress of impatience the degree of harmony expressed in the physician-clergyman team can and ought to be the most reassuring factor.

PERSONAL RELIGION AND POSITIVE HEALTH

by Gary deN. Hough, III, M. D.
Member, Medico-Religious Committee

Whenever physicians consider the impact of religion on medicine, the discussion quickly turns to those areas where the healing art has lost its power—incurable disease, terminal illness, and death. Most thinking men will admit that spiritual faith is indispensable at such times. I would prefer to advance the concept that the Judeo-Christian tradition primarily teaches us a better way of life rather than a better way of death and the treatment of some illnesses requires recourse to this tradition.

All of us recognize a type of patient who drifts from one sympton to another, rarely acutely sick and never really well. Other cases have compensated adequately until faced with an injury from which they continue to suffer beyond a normal convalescent period. Although these persons can be psychiatrically classified, many of them do not warrant a diagnosis of mental illness, and only the most severely incapacitated profit from specialized psychiatric care. Our materialistic society fosters this type of disability with Workmen's Compensation Laws, prolonged civil litigation, and prepaid medical insurance. Modern medicine has failed to provide for these patients, or worse yet, subjects them to expensive investigation to rule out serious organic pathology. No specialty group focuses on their problem, yet no specialty is exempt from their problems, yet no specialty is exempt from their demands. They call loudly for the good old family doctor, and spend their money on cuacks and patent medicines.

If health is something more than the absence of diseases, then our responsibilities to such patients extend beyond the statement that nothing is wrong with your . . . (back, stomach, bladder, etc.). Somehow, we should find a way to motivate these people to a better level of equilibrium with their environment. A technique for converting these half-sick patients into truly healthy individuals would rival the antibiotics in social value.

It is pertinent to contrast these patients with individuals who have been afflicted with chronic illness and permanent disability without losing their self-reliance or emotional independence. What permits some patients to accept handicaps without compromising their functional efficiency? Somehow these individuals acquire a positive attitude towards living which minimizes symptoms and prevents disabililty. Such an attitude is not limited to the handicapped, but is more easily identified there. The development of such an approach to life is clearly within the realm of religion and ethics, and the rehabilitation of persons with de-

fects in the sphere is a proper concern of both medicine and religion.

May I emphasize that I am not discussing the treatment of the mentally ill, nor am I proselyting my own personal religious tenets. I am considering instead, a large group of patients whose symptoms might be attributed to a deficiency disease — a lack of idealism. To combat this syndrome and the materalism which fosters it, we need something better than platitudes and tranquilizers. I feel that the antidote for this deficiency is compounded of both medicine and religion. I feel that both physicians and theologians can improve their formulation of this antidote by mutual discussion of the clinical manifestations of this deficiency state. I hope that the Medico-Religious Committee will consider both dosage schedules and routes of administration.

MEETING THE EMOTIONAL NEEDS OF THE PATIENT

by Harry H. Michelson, M.D.
Member, Medico-Religious Committee

There is little doubt that much of the therapeutic success of our profession is due to the undefined emotional rapport between patient and physician. The most common psychological factor we encounter in the sick is anxiety, which may stem either from the realistic external world or from impulses within the individual. The patient's conscious fears may relate to the danger of chronic invalidism, fear of pain, economic reverses, and postponement of important plans. He may also worry about the surgeon's skill and the expense involved. The anxiety, due to deep seated emotional problems is often highly complex in origin. For the non-psychiatrically trained physician it is best to limit his attention to the patient's conscious feelings even though the doctor may be aware of the presence also of unconscious factors. The art of listening, although time-consuming to the busy practitioner, is often more beneficial in the relief of tension and anxiety than the instant formulas or clinches often offered for the relief of emotional conflicts. It is surprising how frequently the patient achieves understanding and clarification of surface problems by the mere opportunity to talk. Anxiety is also reduced by objective understanding, empathy, patience, cautious explanation, and equanimity in the face of the patient's crisis. We must keep in mind that illness, accidents or surgical procedures are a threat to personal integrity. The patient's response will vary according to his personality, his background, and the meaning he attaches to his illness. The course of his illness may depend very much on our understanding of his idiocyncrasies and his past pattern of reactions to stress.

In our search for anxiety-reducing means for the physically ill, the care of the patient's spiritual needs can be of immeasurable therapeutic benefit. For a great many spiritual advisors, the knowledge of pastoral psychology has become a valuable tool in dealing with the physically ill. It is true that many people cannot accept the gratification and comfort of religion and are, therefore, resistive to ministerial counseling. However, whenever possible or when indicated, the physician should mobilize the help of the clergy. The results of such counseling will be gratifying provided the patient agrees to it without reservation. The clergyman, from whom such advice is sought, may have a substantial effect on the course of the patient's illness. The spiritual adviser should use the patient's religious faith as a supportive measure and not probe deeply into the psychological origins of his reactions to physical stress. As physicians we should be aware of the fact that many clergymen are often better acquainted with the patient's background, his family inter-relationships, and his past adjustment patterns, than we are.